by 1947 had gained widespread international recognition. Behçet deserves to have the disease named after him, because he was the first modern author to group the various ophthalmic, dermatologic, and oral-genital lesions together as a syndrome.[3]

On the other hand, Dr Adamantiades presented a case of a young man with recurrent ocular lesions, and he observed that his patient had many other manifestations as well. It is possible that this young man was suffering from what we called Behçet's disease today. However, in his case report, Dr Adamantiades thought three possible etiologies responsible for the clinical picture: syphilis, tuberculosis, or staphylococcal infection. He didn't recognize the true nature of the disease and therefore was not able to describe it as a syndrome. The patient received antisyphilitic treatment; however, the disease was not cured. In addition, the presentation of the case was from an ophthalmologist's perspective for the most part and naturally focused on the ocular lesions, as its title discloses. Others reported similar observations long before Adamantiades. His report contains nothing original in this regard.

As to answer the other questions, we consider endovascular techniques a potential future option in the treatment of these patients, as mentioned in our article.[4] However, it is not possible to visually define the extent of disease within arterial segments with this approach. Since surgical excision is not possible here, the diseased tissue is left in place. Furthermore, whether or not these devices may trigger a superposing inflammatory response will remain uncertain until more data become available. Suture line reinforcement is strongly advisable in vasculo-Behçet cases. Inspection of major pathologic evidence in adventitia or transected aortic wall may give some clues for delineating the diseased segments intraoperatively, though this represents a continuing challenge.

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Regarding "Extension of saphenous thrombus into the femoral vein: a potential complication of new endovenous ablation techniques"

Although the extension of saphenous thrombus into the femoral vein is a potential complication of new endovenous ablation techniques (J Vasc Surg 2005;41:130-5), it is very rare. Most published data on endovenous laser ablation have supported performing the technique in the absence of general or spinal anesthesia.[1,2] However, it is of great importance to perform the procedure under adequate tumescent anesthesia, which allows the operator to obtain feedback from the patient and avoid overtreatment of the vein. Complete collapse of the vein also minimizes thrombotic occlusion. Insertion of the catheter, whether radiofrequency or laser, into the common femoral vein (CFV) must be avoided at all costs to reduce damage to the CFV or the great saphenous vein (GSV) proximal to the epigastric vein.

In our own experience at the Arizona Heart Institute with >1,000 cases, we have seen only one pulmonary embolus in a patient with leg ulcer who weighed >350 pounds. Her ultrasound scan on the fifth day did not show any thrombus extending into the CFV. She was not as ambulatory as most of our other patients, who return to normal activity in 2 days.

The original instructions for radiofrequency ablation (VNUS closure system, San Jose, Calif) called for placement of the catheter in the CFV with pullback into the GSV. After Dr Hingorani's presentation at the American Venous Forum meeting in February 2004,[3] we cautioned the company that this practice could lead to intimal damage, especially in smaller veins.

Maintaining physiologic drainage at the saphenofemoral junction is the most important aspect in the endovenous closure technique, which has been well illustrated in our observations and by Pichot et al.[4] We strongly believe that the procedure should be done under complete tumescent anesthesia, without any intravenous sedation. Furthermore, only minimal manipulation should be done at the saphenofemoral junction.

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Reply

We greatly appreciate the comments of Dr Ravi and his colleagues from the Arizona Heart Institute. With an experience of >1,000 endovenous cases, it is commendable that they observed only one pulmonary embolism. We wonder if all of their patients (beyond their published early experience) had early postoperative duplex scanning and what was the rate of extension of thrombus from the saphenous vein toward the common femoral vein (CFV)?

The purpose of our communication was to stress that the extension of saphenous thrombus into the femoral vein after endovenous ablation may not be as rare as originally believed, especially in early experience with this technique.

Their comment that avoiding insertion of the catheter, whether radiofrequency or laser, into the CFV must be avoided to reduce damage to the CFV or the great saphenous vein (GSV) proximal to the epigastric vein makes sense, although no evidence is given that it indeed makes a difference. Most manufacturers, as well as Min et al,[1] recommend advancing the catheter into the common femoral vein and pulling it back to the saphenous vein. In Min's large experience, no deep venous thrombosis was reported in 499 patients, despite commencing the ablation above the epigastric vein (5 to 10 mm from the saphenofemoral junction). We have always positioned the laser probe 10 mm distal to the epigastric vein and have modified our technique to keep manipulation

above this level to a minimum to minimize this complication. Complete emptying of the vein with leg elevation and adequate tumescent anesthesia is probably even more important, as mentioned by Dr Ravi and colleagues, to avoid thrombotic occlusion of the saphenous vein, both to decrease the chance of thrombus extension as well as recanalization in the long-term.

The mode of anesthesia might have also contributed to the development of this complication in our patients. Because of the distances patients travel for treatment at our center, it has been our practice to perform stab avulsion of all branch varicosities concomitantly under general or epidural anesthesia. The resultant longer period of perioperative immobility could have contributed to proximal thrombus formation. Analysis in our patients, however, has revealed correlation of thrombus extension only with increasing age.

Our overall experience with this technique has been rewarding and patient satisfaction has been high. We sincerely hope that our paper will be viewed as our intention was: to call attention to potential perioperative thrombotic complications and to decrease morbidity of an effective endovenous procedure for the treatment of patients with varicose veins.

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